



Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-4344

Poliomyelitis

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Epi Link: _____

☐ Outbreak-related

LHJ Cluster# _____

LHJ Cluster
Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date: ____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age ____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Fever** Highest measured temp: ____ °F

Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ **Headache**

☐ ☐ ☐ ☐ **Stiff neck/back**

☐ ☐ ☐ ☐ **Muscle aches or pain (myalgia)**

☐ ☐ ☐ ☐ Malaise

☐ ☐ ☐ ☐ Nausea

☐ ☐ ☐ ☐ Vomiting

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Immunocompromised

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ **Paralysis or weakness**

☐ Acute flaccid paralysis ☐ Asymmetric

☐ Symmetric ☐ Ascending ☐ Descending

☐ ☐ ☐ ☐ Decreased/absent tendon reflexes

☐ ☐ ☐ ☐ Acute onset

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ **Hospitalized for this illness**

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ **Died from illness** Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ **Ever received polio containing vaccine**

Number of doses prior to illness: _____

Dose 1 Type: _____ Date received: ____/____/____

Dose 2 Type: _____ Date received: ____/____/____

Dose 3 Type: _____ Date received: ____/____/____

Dose 4 Type: _____ Date received: ____/____/____

Dose 5 Type: _____ Date received: ____/____/____

☐ ☐ ☐ ☐ **Vaccine up to date for current disease**

Vaccine series not up to date reason:

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous infection confirmed by laboratory

☐ Previous infection confirmed by physician

☐ Parental refusal

☐ Other: _____

☐ Unk

Laboratory

Collection date ____/____/____

Source _____

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

P N I O NT

☐ ☐ ☐ ☐ ☐ **Polio virus culture (stool, CSF or oropharyngeal secretions)**

Vaccine strain: ☐ 1 ☐ 2 ☐ 3

Wild strain: ☐ 1 ☐ 2 ☐ 3

☐ ☐ ☐ ☐ ☐ **Pleocytosis (CSF)**

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:

Exposure period

-35 -3

Contagious period

1 week prior

to 6+ weeks after onset

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine

Out of: ☐ County ☐ State ☐ Country

Destinations/Dates: _____

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed or probable case**

☐ ☐ ☐ ☐ Contact with recent foreign arrival

Specify country: _____

☐ ☐ ☐ ☐ Contact with recent OPV vaccinee

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

Y N DK NA

☐ ☐ ☐ ☐ Congregate living

☐ Barracks ☐ Corrections ☐ Long term care

☐ Dormitory ☐ Boarding school ☐ Camp

☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Source of drinking water known

☐ Individual well ☐ Shared well

☐ Public water system ☐ Bottled water

☐ Other: _____

☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)

☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool

☐ ☐ ☐ ☐ Employed in child care or preschool

☐ ☐ ☐ ☐ Do any household members work at or attend childcare or preschool

☐ ☐ ☐ ☐ Documented transmission from this case

☐ Child care ☐ School ☐ Doctor's office

☐ Hospital ward ☐ Hospital ER

☐ Hospital outpatient clinic ☐ Home

☐ College ☐ Work ☐ Military

☐ Correction facility ☐ Church

☐ International travel ☐ Other: _____ ☐ Unk

PUBLIC HEALTH ACTIONS

☐ Strict isolation for incubation period

☐ Public announcement recommended

☐ Other, specify: _____

NOTES

Investigator _____

Phone/email: _____

Investigation complete date ____ / ____ / ____

Local health jurisdiction _____

Record complete date ____ / ____ / ____